Chapter 4
Home Health Services

Maryland Home Health Agency Services: Overview and Definition

In the introduction to its 1993 legislatively-mandated study of community-based long term care services in Maryland, the former Health Resources Planning Commission noted the growing importance of health care provided to "frail, ill, disabled, or cognitively impaired" individuals in their homes. The historic and demographic factors that had originally fostered the growth of the home care industry – the aging of the population, the growing number of women working outside the home, double-digit inflation in health care costs, the Medicare PPS system and other, subsequent changes in Medicare payment policies, advances in home care techniques and technology – continue to shape that industry. Community-based health care services remain vitally important from a public policy perspective, because of their relationship to institutional care, their cost-effectiveness compared to high-cost institutional care, and their impact on federal and State budgets.[64]

For purposes of this paper, it is important to distinguish between the entities that may, under different sections of Maryland law, come into the homes of ill and often vulnerable people to provide varying levels of home health or personal care. The Commission regulates through Certificate of Need the entry into this market of only one of these entities, home health agencies, and has no direct role in monitoring the quality of care provided by a subsequently licensed and Medicare-certified home health provider. Patients and families may not know what level of initial scrutiny and continuing oversight applies to the caregivers that come into their homes: the manner and degree to which home care regulation is coordinated among various agencies remains an issue for State policymakers.

What home health agencies are, and what they are not, is an important starting point in the examination of the appropriate role of government in overseeing home-based health care. Licensing statute defines a "home health agency" as "a health-related institution, organization, or part of an institution that: (1) is owned or operated by one or more persons, whether or not for profit and whether as a public or private enterprise; and (2) directly or through a

[64] Maryland Health Resources Planning Commission, *Study of Community-Based Long Term Care Services, Part I: Home Care Services*, November 30, 1993, p.1. HB 1066, enacted in 1993, removed the sunset of legislation that had created the category of home care provider known as "residential service agencies" (Chapter 529, Acts 1990), but also required the former HRPC to "conduct a comprehensive study of community-based long term care services, including but not limited to home health agencies, residential service agencies, durable medical equipment providers, and personal care service providers, to assess the impact these services have on access, cost, and quality of care."

contractual arrangement, provides to a sick or disabled individual in the residence of that individual skilled nursing services, home health aid services, and at least one other home health care service that are centrally administered."[65] The statute goes on to define "home health care" services as "any of the following services that are provided under the general direction of a licensed health professional practicing within the scope of their practice act," including audiology and speech pathology, dietary and nutritional services, drug services, "home health aide," laboratory, medical social services, nursing, occupational therapy, physical therapy, and the "provision of medically necessary sickroom equipment and supplies." At §19-404, the "rules and regulations" applicable to the licensure of home health agencies require annual renewal of the license, and set forth detailed administrative procedures and clinical practices that home health agencies must follow. An applicant for a home health agency license must demonstrate the ability to provide "appropriate home health care to patients who may be cared for at a prescribed level of care, in their residence instead of in a hospital, and skilled nursing, home health aide, and at least one other home health care service that is approved by the Secretary."[66] And, significantly, a home health agency must obtain a Certificate of Need in order to seek Maryland licensure and certification for Medicare reimbursement.

Medicare is the most important payer of home health agency services, and sets standards that are widely adopted by other payers for eligibility, staffing, billing methods, reimbursement levels, and which providers and services can be reimbursed. The major categories of services included in the scope of home health agency care, reimbursed by Medicare, include:

- Skilled nursing care on a part-time, intermittent basis;
- Physical and occupation therapy, and speech-language pathology services;
- Medical social services;
- Home health aide services for personal care related to the treatment of the beneficiary's illness or injury, on a part-time or intermittent basis; and
- Medical supplies and durable medical equipment (with a 20 percent beneficiary co-pay.)

In Maryland, many other categories of health and personal care providers may serve clients in their homes. These entities are not home health agencies, but may give, in some combination, essentially the same services as those delineated in statute as appropriate for home health agencies to provide. Only home health agencies must obtain CON approval to enter this market, and (with the exception of some Medicare Part B "medical services") only home health agencies receive reimbursement by Medicare. The 1987 revision of the home health agency statute required these agencies to provide at least three skilled services – skilled nursing services, home health aide

[65] Health General Article §19-401, Annotated Code of Maryland.
[66] Health-General Article §19-406.

services, and at least one other from the list in statute, described above.

In order to circumvent this requirement – and the need to obtain a CON – entities could provide two of the three skilled services, or three or more services, as long as they did not include skilled nursing or home health aide services.[67] Attempting to close this loophole by requiring licensure for any entity providing at least one skilled service in the home, the General Assembly in 1990 created the category of "residential service agencies" (RSAs), which subsequently was expanded to include providers of invasive medical equipment and services, and of durable medical equipment, such as respiratory care equipment and hospital beds. Although required to obtain a license from the Department of Health and Mental Hygiene, RSAs are not surveyed on-site prior to licensing, and do not require a CON. There are currently 220 licensed RSAs in Maryland, according to the DHMH Office of Health Care Quality (OHCQ).

In 1992, the legislature responded to growing concerns about unregulated entities referring nurses to health care facilities by enacting provisions that placed "nursing staff agencies" under the authority of the State Board of Nursing, to help ensure that nursing personnel were appropriately licensed or certified before their assignment to a facility. This credentials check is essentially the extent of the Board's responsibility; the agencies are not required to monitor the quality of the services provided by their nurses. Each worker's professional license or certification provides the primary means of discipline or complaint against an agency nurse or LPN.

Still another source of nursing and other home care workers are the nurse registries, whose activities are regulated by the State's Department of Labor, Licensing, and Regulation (DLLR) through the Employment Agency Act. A health care worker becomes an independent contractor, with the assistance of the employment agency; nothing in the Employment Agency Act addresses the qualifications of the workers, or the way in which they perform their duties. As many as 45 agencies registered with DLLR may refer workers to facilities or homes to provide home health services, with no requirement that their health care workers function under the supervision of a licensed health professional. Considering the amount of home care provided by entities that are *not* home health agencies, the uncoordinated growth of the home care industry has produced a situation in which "different regulations [are] applied to the same services provided by different organizations."[68] The wide variation in the degree to which health care workers in the home are accountable for their qualifications, performance, and behavior raises a concern for the patient-consumer, and makes a comprehensive understanding

[67] Licensing and Certification Administration, DHMH (now Office of Health Care Quality*), Report of the Advisory Committee on Home-Based Health Care Services*, December 1, 1998, pp. 4-5

[68] This conclusion of the 1998 Advisory Committee (*Report*, p. 5), and the legislative proposal that emerged from the Committee's work, are discussed further in Section V.

of the home health care industry difficult to achieve.

Supply and Distribution of Home Health Services

The adjusted number of home health clients and agencies by jurisdiction in Maryland for fiscal years 1996 through 1998 is provided in Table 4-1.[69] Statewide, 101 home health agencies were licensed to serve Maryland jurisdictions in fiscal year 1998. About one-half (53) of those agencies were freestanding, while hospital-based agencies accounted for 22 of the 101 Maryland home health agencies, one agency was nursing home-based, and two were operated by continuing care retirement communities. County health departments operated ten home health agencies in fiscal year 1998, and thirteen home health agencies were operated by HMOs in the same fiscal year.

[69] Adjustments were made to estimate the number of clients served by jurisdiction when that data was missing from the *Maryland Home Health Agency Annual Report*. This table has been adapted from the Commission's *Maryland Home Health Agency Statistical Profile and Trend Analysis, FY 1998*, June 2000.

Table 4-1
Home Health Agencies and Clients by Jurisdiction, FY 1996-1998

Jurisdiction of Client Residence	Fiscal Year 1996		Fiscal Year 1997		Fiscal Year 1998	
	Number of Clients	Number of Home Health Agencies	Number of Clients	Number of Home Health Agencies	Number of Clients	Number of Home Health Agencies
Western Maryland						
Allegany County	1,923	4	2,148	5	1,388	6
Carroll County	2,534	20	2,185	19	1,931	11
Frederick County	1,725	9	2,461	11	2,365	4
Garrett County	663	2	600	4	605	8
Washington County	2,347	9	1,984	9	2,413	
Total	9,192		9,378		8,702	
National Capital Area						
Montgomery County	16,000	31	14,852	29	15,658	28
Southern Maryland						
Calvert County	738	16	936	16	760	14
Charles County	1185	14	1,341	15	1,166	16
Prince George's County	11044	33	11,321	28	9,161	35
St. Mary's County	736	10	899	9	920	11
Total	13,703		14,407		12,007	
Baltimore Metropolitan Area						
Anne Arundel County	9064	36	9,138	38	8,780	35
Baltimore County	22925	38	20,619	36	20,133	36
Baltimore City	26,389	31	25,040	30	22,457	26
Harford County	5511	25	5,497	25	5,708	23
Howard County	2915	30	2,719	34	2,545	28
Total	66,804		63,013		59,623	
Eastern Shore						
Caroline County	480	5	382	3	168	3
Cecil County	1,385	15	1,424	1	1,633	15
Dorchester County	501	2	271	2	113	2
Kent County	395	2	490	2	455	3
Queen Anne County	804	7	759	5	667	6
Somerset County	448	5	560	4	445	7
Talbot County	742	4	206	7	268	2
Wicomico County	1,555	5	1,847	2	1,819	9
Worcester County	788	5	994	8 5	1,031	8
Total	7,098		6,933		6,599	
Maryland Total	**112,797**		**108,583**		**102,589**	

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

Table 4-2
Summary of Recent Closures/Mergers of Home Health Agencies
Maryland: January 1, 1997 – May 1, 2000

Type of Closure	1997	1998	1999	2000*	TOTAL
Closed HHAs of Local County Health Depts.	5	2	3	0	10
Closed Private HHAs	4	4	5	2	15
Closed and Merged Private HHAs	4	7	8	1	20
TOTAL	**13**	**13**	**16**	**3**	**45**

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000. *Data for 2000 is Jan – May only

Changes in Medicare reimbursement and administrative policies have had a significant impact on Maryland home health agencies over the past three years. Table 4-2 quantifies this impact: 25 home health agencies closed (10 local county health department and 15 private agencies) between January 1, 1997 and May 1, 2000. Additionally, 20 home health agencies individually closed as separate licensed entities and were acquired by or merged with other existing agencies. This activity has left a total of 76 licensed home health agencies (including branches) in Maryland, as of May 1, 2000 -- a 33 percent statewide decline in the number of home health agencies serving Maryland clients, from 113 agencies in 1997. About 44 percent of Maryland's agency closures were the result of mergers between existing agencies, which allowed for continued access to home health services in those jurisdictions. However, several county health department agencies closed during the last three years, citing substantial declines in home health client referrals and revenues. Since many of these county agencies served the indigent population in rural areas, the impact of these closures on continued access to needed home health services is an area for continuing scrutiny by the Commission.[70]

Data reported on agency ownership in fiscal year 1998 indicate that 56 of the 101 licensed agencies were private, for-profit entities. Private, non-profit agencies accounted for 35 of the total licensed home health agencies. The remaining 10 agencies were operated by government agencies.

In addition to the closures of licensed and operating home health agencies during this period, 29 CONs were relinquished by entities granted approval by the Commission. An additional six CONs are seriously in default on their performance requirements, and presumably will also be abandoned.

[70] For more detail on these closures, refer to Appendix B in the Commission's *An Analysis and Evaluation of Certificate of Need Regulation in Maryland-Working Paper: Home Health Services*, August 18, 2000.

More than eighty-four percent of licensed Maryland home health agencies were certified for participation in the Medicare program: 85 of the 101 participating home health agencies were Medicare-certified, as reported in the Commission's Fiscal Year 1998 annual survey of home health agencies. Table 4-3 shows payment source for home health agency clients, with Medicare clients comprising more than half of those served by home health agencies during Fiscal Year 1998.

Table 4-3
Maryland Home Health Clients (Unduplicated)
by Payment Source: Fiscal Year 1998

Payment Source	Number of Clients	Percent of Total
Medicare	50,344	50.07%
Medicaid	4,035	4.01%
Blue Cross	7,299	7.26%
Commercial Insurance	11,319	11.26%
Private Pay	1,907	1.90%
Health Maintenance Organization	19,294	19.19%
Other	5,992	5.96%
Unknown	360	0.36%
MARYLAND TOTAL	**100,550**	**100.00%**

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

Expressed as the number of home health visits during the same fiscal year, Medicare's predominance in this sector translates to nearly three-quarters (72.8 percent) of that year's home health agency visits for Maryland residents, as shown in Table 4-4. Clients enrolled in the Medicare program had an average of 25.4 visits per client. By contrast, the Medicaid program accounted for 2.6 percent of total home

health visits to Maryland residents, with an average of 11.2 visits per client. Clients financed by Blue Cross represented 3.4 percent of the total, an average of 8.1 visits, while commercial insurance plans accounted for 6 percent, an average of 9.3 visits per client. The remaining visits were financed

by private pay (1.6 percent; 14.8 visits per client), health maintenance organizations (10.6 percent; 9.7 visits per client), and "other" sources (3.0 percent; 8.8 visits per client), with an "unknown" payment source reported for 0.1 percent of home health agency visits to Maryland residents during Fiscal Year 1998.

Table 4-4
Maryland Home Health Visits and Visits Per Client
by Payment Source: Fiscal Year 1998

Payment Source	Number of Visits	Percent of Total	Visits Per Client
Medicare	1,280,723	72.78%	25.4
Medicaid	44,978	2.56%	11.2
Blue Cross	59,080	3.36%	8.1
Commercial Insurance	105,203	5.98%	9.3
Private Pay	28,187	1.60%	14.8
Health Maintenance Organization	186,577	10.60%	9.7
Other	52,898	3.01%	8.8
Unknown	1,972	0.11%	
MARYLAND TOTAL	**1,759,618**	**100.00%**	**17.5**

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

Trends in the Utilization of Home Health Services

In its report *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, released in June 2000, the Commission presented a comprehensive statistical portrait not only of utilization and payment source data for Fiscal Year 1998, but also an analysis of the trends in all aspects of home health agency utilization, payment, and organizational structure. Some highlights from that trend analysis help to illustrate the way this sector of the health care industry has changed over the last three years.

- **Total Number of Admissions and Reporting Agencies**

Between 1996 and 1998, home health agency admissions declined across the State,

from 158,364 to 141,598, a 10.5 percent decline in the number of admissions over the study period. This decline reflects the decrease in the number of reporting home health agencies, from 115 agencies in 1996 to 98 agencies in 1998.

Table 4-5
Total Number of Home Health Agency Admissions
Maryland, Fiscal Years 1996 - 1998

Fiscal Year	Total Number of Admissions	Number of Reporting Home Health Agencies
1996	158,364	115
1997	140,157	109
1998	141,598	98

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

- **Home Health Agency Admissions by Agency Type**

Home health agency admissions by type of agency also shifted during this three-year period. While admissions to freestanding home health agencies declined, from 57.8 to 51.9 percent of the total, the proportion of admissions to hospital-based home health agencies increased, from 27.5 to 36.6 percent, during the same period. Admissions to agencies operated by local health departments also declined, from 3.5 percent of admissions in 1996 to 2.1 percent of admissions in 1998 – arguably, both cause and effect of the ten county agencies that closed between January 1, 1997 and May 1, 2000.

Table 4-6
Percent Distribution of Home Health Agency Admissions by Agency Type, Fiscal Years 1996 – 1998

Agency Type	1996	1997	1998
Freestanding	57.8%	52.2%	51.9%
Hospital-Based	27.5%	33.6%	36.6%
HMO-Based	10.4%	10.4%	9.0%
Local Health Department	3.5%	3.0%	2.1%
Other	0.8%	0.8%	0.4%

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

- **Home Health Agency Admissions by Referral Source**

While the majority of admissions have consistently been referred to home health care by hospitals, during the three-year period from 1996 to 1998, the second most frequent source of referral to home health care has been by private physician offices. Both of these referral sources combined comprise about 73 percent of all admissions to home health care. Two other referral sources showed a dramatic shift from 1996 to 1998: HMO referrals declined from 12.6 percent in 1996 to 5.6 percent in 1998, and referrals from sub-acute programs and assisted living facilities, grouped as "other" in Table 4-7, rose during the same period from 4.6 percent in 1996 to 10.3 percent in 1998. This change in referral source patterns arguably reflects the recent increase in the development of assisted living facilities, and their use of home health as a way of providing skilled nursing services to an increasingly frail population.

Table 4-7
Percent Distribution of Home Health Agency Admissions by Referral Source, Fiscal Years 1996 - 1998

Type of Referral Source	1996	1997	1998
Hospital	54.8%	52.4%	53.9%
Private Physician	18.6%	19.8%	19.4%
HMO	12.6%	11.5%	5.6%
Nursing Home	3.4%	4.7%	4.6%
Family/Self	3.0%	2.6%	2.3%
Other	4.6%	6.2%	10.3%*
Unknown	3.1%	2.9%	3.9%

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.
*For FY 1998, "other" category includes referrals form sub-acute program (2.2%) and other referral (8.1%)

- **Home Health Agency Discharges by Disposition**

During the three-year study period, a significant and consistent majority of clients have been discharged with home care goals met, with a slight increase in the percentage of this group relative to all discharges from 65.8 percent in 1996 to 67.8 percent in 1998. The percent of total discharges transferred to other health care facilities or another home health agency very slightly increased from 13.3 percent in 1996 to 14.8 percent in 1998. The largest proportion of discharges transferred to another setting were transferred to an acute care hospital; that percentage rose from 9.8 percent in 1996 to 11 percent in 1998. Based on this trend, most home health clients successfully complete their goals and are able to remain in their home setting, although a fairly consistent number of clients will return to

some institutional setting for needed health services. Clients who no longer met reimbursement criteria accounted for the third highest proportion of total discharges from home health care across the three-year period from 1996 to 1998. This is consistent with the strict "homebound" criteria currently imposed by Medicare.

Table 4-8
Percent Distribution of Home Health Agency Discharges by Disposition, Fiscal Years 1996 – 1998

Discharge Disposition	1996	1997	1998
Goals Met	65.8%	66.4%	67.8%
Transferred to Acute Hospital	9.8%	10.2%	11.0%
Transferred to Another Institutional Setting*	1.5%	2.2%	1.4%
Transferred to Hospice	0.8%	0.7%	1.0%
Transferred to Another Home Health Agency	1.2%	1.2%	1.4%
Death	3.4%	2.5%	2.9%
No Longer Meet Reimbursement Criteria	8.2%	7.1%	8.0%
Non-Compliance or Client Refused Services	2.0%	2.3%	2.1%
Other	7.3%	7.4%	4.5%

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.
*"Another institutional setting" includes comprehensive care or extended care facilities, chronic hospital or rehabilitation facility.

- **Trends in Home Health Agency Clients and Visits by Payment Source**

From 1996 to 1998, the total number of Maryland residents ("unduplicated clients") receiving home health care has declined by 9 percent, and the number of visits made to home health agency clients has also declined, by 15 percent. However, these changes in utilization vary across payment sources. The greatest decline in both the number of clients and visits were for Maryland's Medicaid home health agency clients: a 59 percent decline in Medicaid clients served, and a 76 percent decline in the number of Medicaid visits. The second greatest decline was for Medicare clients, with a 16 percent decline in the number of clients and 18 percent decline in the number of visits. Interestingly, while the number of home health clients covered by Blue Cross/Blue Shield, commercial and private insurance declined by 10 percent, the number of visits covered by these payers increased by 8 percent.

Home health agency clients enrolled in HMOs had the greatest increase in both the number of clients served (a 40 percent increase) and home health visits provided (which increased by 82 percent) during the Fiscal Year 1996-1998 period. The decline

in Medicaid and Medicare home health clients and visits concurrent with an increase in both clients and visits for HMO subscribers could reflect the continued growth of managed care in Maryland, and may also indicate some degree of shift in the payer distribution from traditional Medicare and Medicaid to managed care entities funded by those payers.

Table 4-9
Number of Home Health Clients (Unduplicated) and Visits
by Payment Source, Fiscal Years 1996 – 1998

Payer Source	1996		1997		1998	
	No. Clients	No. Visits	No. Clients	No. Visits	No. Clients	No. Visits
Medicare	61,202	1,681,193	57,595	1,467,780	51,406	1,371,936
Medicaid	10,209	192,499	8,349	122,805	4,237	47,247
Private Insurance*	23,227	195,980	21,039	226,072	21,024	211,162
HMO	13,945	105,191	17,074	184,025	19,565	190,901
Other**	4,214	35,502	4,526	67,433	6,357	55,739
TOTAL	**112,797**	**2,210,365**	**108,583**	**2,068,115**	**102,589**	**1,876,985**

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

* Private insurance category includes Blue Cross, commercial and private insurance.
**Other category includes unknown payment source.

- **Maryland's Medicare and Total Maryland Home Health Clients and Visits**

The Medicare program has consistently been the primary payer source for home health care services provided to Maryland residents. Maryland's Medicaid program has historically financed the lowest number of both home health clients and visits. The private insurance industry, which includes Blue Cross, commercial and private insurance companies, has been the second largest payer of home health clients and visits, with HMOs as the third largest payer.

Table 4-10 shows that while Medicare clients have consistently represented about one-half of total Maryland home health agency clients, Medicare has continued to account for a higher percentage (73 percent in 1998) of total Maryland home health care *visits*. This directly relates to the differences in the average number of visits per client for Medicare enrolled clients as compared to all Maryland clients.

Table 4-10
Medicare's Percentage of Total Home Health Clients (Unduplicated) and Total Home Health Visits in Maryland, Fiscal Years 1996 - 1998

Fiscal Year	Medicare Clients (% of Maryland Total)	Total Maryland Clients	Medicare Visits (% of Maryland Total)	Total Maryland Visits
1996	61,202 (54.3%)	112,797	1,681,193 (76.1%)	2,210,365
1997	57,595 (53.0%)	108,583	1,467,780 (70.1%)	2,068,115
1998	51,406 (50.1%)	102,589	1,371,936 (73.1%)	1,876,985

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.

Because Medicare continues to represent the largest proportion of total Maryland home health visits -- although only about one-half of all home health agency clients in a given year are Medicare enrollees -- it is interesting to also compare the average number of visits per client by payment source. The fact that, on average, Medicare home health clients require more visits than clients with other payers may simply be because they are older, more frail, and in need of more home health services.

Table 4-11
Comparison of Average Visits Per Client by Payment Source, Maryland, Fiscal Years 1996 – 1998

Payer Source	1996	1997	1998
Medicare	28	26	26
Medicaid	19	15	11
Private Insurance*	8	11	10
HMO	8	11	10
Other**	8	15	8
TOTAL	20	19	18

Source: Maryland Health Care Commission, *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, June 2000.
*Private insurance category includes Blue Cross, commercial and private insurance.
**Other category also includes unknown payer source.

Commission Staff's summary of the findings in the June 2000 *Statistical Profile and Trend Analysis* of home health agencies in Maryland between fiscal years 1996 and 1998 concluded that, over the three-year study period:

- The number of home health agency admissions, and agencies, has declined.

- The decline in Medicaid and Medicare home health clients and visits concurrent with an increase in home health agency clients and visits by HMOs, may be due to the growth of Medicaid, and to a lesser degree, Medicare managed care in Maryland.
- While Medicare clients have consistently represented about half of total Maryland home health agency clients served, Medicare has continued to account for a consistently higher percentage of total Maryland home health care visits.
- Maryland's average number of home health visits per Medicare user remained constant (as measured in benchmark years 1994 and 1997), while the adjacent states and the United States as a whole continued to increase.

Cost of Home Health Agency Services

Medicare Reimbursement Issues

Most third-party payers, including HMOs and other private carriers, reimburse for home health agency and other home care services. Private insurers will generally cover home health agency care for their beneficiaries when this care substitutes for hospitalization or other institutional care. However, the services provided by home health agencies, in Maryland and across the nation, are primarily a Medicare benefit; in Maryland for Fiscal Year 1998, as noted above, Medicare accounted for over half of the home health agency clients, and nearly three-quarters of the home health visits. Nationally, during calendar year 1998, spending on home health agency care comprised one-quarter of a percent of the total national health expenditures for that year -- $29.3 billion of the $1.15 trillion total. Of that $29.3 billion spent on home health agency care nationwide, $13.1 billion, or approximately 44.7 percent, were Medicare payments.

Because Medicare is the dominant payer in Maryland and the nation as a whole for services provided by home health agencies, Medicare payment policies have a profound influence on the scope and volume of services provided to patient in the home. Understanding and evaluating the impact of Medicare home health payment policies -- and changes in those policies -- is central to an understanding of the home health industry and a marker of how the industry might be expected to change. Although continuing advances in the technology of complex medical care in the home has also played an important role in increased utilization and rising expenditures in the Medicare home health sector, Medicare eligibility and reimbursement policies largely determine both the clinical and the financial environment of this important setting for health care services.[71]

[71] This discussion of the history of changes to Medicare home health reimbursement policy and the initial impact of the IPS and coming PPS system is adapted from the *Maryland Home Health Agency Statistical Profile and Trend Analysis, FY 1998*, which updated a similar analysis in a report by the former HRPC on the findings of its IPS workgroup, *Medicare's Home Health Agency Interim Payment System: An Assessment of the Potential Impact in*

Since the Medicare program was created in 1965, home health has been included as a covered benefit for beneficiaries who meet certain eligibility criteria.[72] The nature and scope of this benefit has changed periodically over the last 35 years, in response to federal legislation and, in particular, to a landmark court case. These changes have altered the way beneficiaries use Medicare home health.

Amendments to the Social Security Act enacted in 1972 established the authority to impose cost limits on Medicare services, including home health, and benefits were extended to individuals under 65 with qualifying disabilities or chronic renal disease. Medicare published cost limits on home health visits for the first time in 1979. The Omnibus Budget Reconciliation Act of 1980 (OBRA) removed the distinction between Part A (post-acute) and Part B (non post-acute) home health, and also eliminated the 100-visit limit for eligible beneficiaries. Utilization and expenditures for home health care services accelerated with the 1980 OBRA changes: between 1980 and 1985, the national proportion of Medicare beneficiaries receiving home health care rose from about 3.4 percent to 5.1 percent, and home health expenditures nearly doubled, from $1.5 billion to $2.7 billion.[73]

In response to this rapid rise in home health care utilization and Medicare expenditures, HCFA imposed a stricter interpretation of its criteria for home health coverage. However, a class action suit soon challenged this strict view of eligibility, and the settlement of *Duggan vs Brown* [74] in 1989 resulted in significant revisions to the Medicare Home Health Agency Manual, to conform Medicare coverage criteria to the Court's decision. The result was more beneficiaries qualifying for home health agency services, and more visits for each client. This trend continued well into the 1990s: national data show that while the average Medicare payment per visit grew only slightly, the average annual number of Medicare visits per home health user more than doubled from 36 visits to 73 visits, a 103% increase[75] Total home health expenditures rose from $4.6 billion in 1990 to $16.7 billion in 1997.[76]

Maryland and the Need for Further Study, published in October 1998.

[72] To qualify for Medicare home health, a beneficiary must be physician-certified as homebound; in need of intermittent skilled nursing care, or physical or speech therapy; and, under a physician's care who certifies that care in the home is necessary. The physician also must establish and periodically review the patient's plan of care. A beneficiary who only requires personal care, and has no skilled medical care needs, does *not* qualify for the home health benefit under Medicare.

[73] U.S. Department of Health and Human Services, Heath Care Financing Administration, *A Profile of Medicare Home Health*, August 1999.

[74] A class action suit, *Duggan v. Bowen*, was filed by a coalition of beneficiaries and providers in 1997. The Court agreed with the plaintiff's charge that Medicare's interpretation of the statutory phrase "part-time or intermittent" was too narrow, leading to the denial of care for eligible beneficiaries.

[75] Maryland's experience was quite different from the nation's during the same period: Maryland data from 1990 to 1997 shows an increase of only 28% in the average number of Medicare visits per home health client.

[76] U.S. Department of Health and Human Services, Health Care Financing Administration, *A Profile of Medicare Home Health*, August 1999.

The significant increases in home health expenditures and utilization nationally raised concerns about waste, fraud and abuse, and in 1995, the DHHS Office of the Inspector General (OIG) and the General Accounting Office (GAO) began a comprehensive anti-fraud initiative, Operation Restore Trust (ORT), conducting fraud investigations of several states in which utilization and Medicare expenditures had risen disproportionately. The instances of inappropriate payments and fraudulent behavior[77] led Congress to include significant modifications to the Medicare program, particularly to home health, in the Balanced Budget Act (BBA) of 1997; these changes were intended to slow the rate of expenditure growth, provide incentives for efficiency in the delivery of care, and ensure that Medicare paid for appropriate services.[78]

The BBA provided for the establishment of a Prospective Payment System for all costs of home health services, and, during the development of PPS, made immediate, incremental changes to Medicare's cost-based reimbursement system in an Interim Payment System (IPS). The IPS, which took effect October 1, 1997, continued to reimburse home health agencies based on costs, but imposed drastically tighter spending limits. One part of this limitation on home health agency payments established a per-visit limit based on 105 percent of the national median per-visit cost, and another imposed a "per-beneficiary limit" (PBL), based on each home health agency's average payment for all services provided to each client. The BBA rules also in effect revived the old distinction between post-acute and non post-acute home health services.[79] A supplemental appropriations act passed in 1999 revised the IPS, moderately increasing both the per-visit and the per-beneficiary cost limits on home health visits, and delaying the implementation of the full PPS for one year, until October 1, 2000.

Another "refinement" of BBA was enacted in December 1999: the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act (BBRA), commonly referred to as the "BBA Fix",[80] included several significant changes to Medicare's payment for home health services for fiscal year 2000. The "BBA Fix" delayed a planned 15 percent reduction in payment rates originally scheduled to take effect October 1, 2000 for a year; increased by 2 percent the per-beneficiary limits for agencies with limits below the national median; added a $10 per beneficiary payment to agencies, to defray costs of the data collection and reporting requirements under the Outcome and Assessment Information Set (OASIS) required by the 1997 BBA. The measure also clarified surety bond requirements imposed by BBA, and reduced the amount on which bonding

[77] General Accounting Office, GAO/OSI-95-17, *Medicare: Allegations Against ABC Home Health Care*, July 1995 provides a representative example.

[78] U.S. Department of Health and Human Services, Heath Care Financing Administration, *A Profile of Medicare Home Health*, August 1999.

[79] Ibid

[80] *Provider*, American Health Care Association, February 2000, page 29.

was required. It removed durable medical equipment from the consolidated billing requirement, permitting DME providers to bill Medicare directly, rather than the individual agency.

HCFA published proposed rules for PPS in the October 28, 1999 edition of the *Federal Register* (64 Fed. Reg. 58134) under which PPS will formally replace the current system of retrospective payment based on "reasonable costs"[81] with a new payment system, effective October 1, 2000,[82] under which home health agencies would be paid a fixed amount for each patient for each 60-day episode of care, regardless of the number of days of care actually provided during the 60-day period.[83] In the proposed rule, the number of 60-day episodes for home health patients is not limited, and can be consecutive, if required by the physician's plan of care.[84] A provider case-mix adjustment formula further complicates this system. Intended to measure the intensity of care and services required for each patient and translate it into an appropriate payment level, this calculation quantifies a patient's need for care resources based on the combination of clinical, functional, and service utilization indicators measured at the start of the 60-day period,[85] and results in the patient being assigned into one of 80 Home Health Resource Groups (HHRGs). The proposed new fixed payment system also adjusts for geographical differences in wages. Despite the level of detail and complexity involved in these imminent rule changes, there remain many uncertainties concerning the advent of PPS for Medicare reimbursement of home health agencies.[86]

A major concern, as Maryland home health agencies move toward full implementation of PPS, is that -- in order to keep costs below the aggregate per-visit cost limits – agencies may respond by eliminating or reducing certain high-cost services, such as infusion therapy. Beneficiaries needing these services may be forced out of their homes and into institutional settings, or they

[81] Durable medical equipment (DME) is a covered home health service that is not currently paid on a reasonable cost basis, but is paid on a fee schedule basis when covered as a home health service under the Medicare home health benefit. Under the HHA PPS, DME covered as a home health service as part of the Medicare home health benefit will continue to be paid under the DME fee schedule.

[82] All HHAs are to be paid under PPA effective upon implementation October 1, 2000. There is no transition by cost reporting period.

[83] The 60-day episode payment covers one individual for 60 days of care regardless of the number of days of care actually provided during the 60-day period unless there is a partial episode payment (PEP) adjustment, significant change in condition (SCIC), low-utilization payment adjustment (LUPA), additional outlier payment, or medical care determination.

[84] The Remington Report, *Home Health Agency Prospective Payment System Proposed Rule*, Supplement to November/December 1999 Issue.

[85] *Federal Register*, October 28, 1999, Volume 64, Number 208, p. 58177.

[86] In response to the uncertainty and concern generated by BBA's changes and especially by the imposition of first IPS, then PPS, the former HRPC convened a workgroup of Maryland-based home health agencies in July 1998, and in October 1998 published a comprehensive report describing the initial impact of IPS and exploring the likely future impact of the new payment systems. A detailed discussion of the workgroup's findings may be found in the Commission's June 2000 *Statistical Profile and Trend Analysis* report.

may forgo receiving the required services. Either response carries implications for potential increases in system-wide health care costs, as well as a diminished quality of life for the patient. Further, the reductions in Medicare payments to home health agencies has already resulted in a significant number of agency closures and holders of CONs to establish agencies relinquishing these CONs. Continued access to needed home health services could be jeopardized, and low-volume agencies in rural jurisdictions would most likely have the greatest difficulty in remaining financially viable. Another concern is that Medicare home health payment cuts could shift costs to state Medicaid programs, resulting in unanticipated, non-budgeted expenditures.[87] Concerns over the impact of PPS on access to home health agency services is by no means limited to Maryland. Studies recently conducted by the George Washington University (GWU) Medical Center examined the impact of Medicare's IPS on access to home health services across the nation. *An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Hospital Discharge Planning*, released in January 2000,[88] provides evidence that the "sicker beneficiaries have been disproportionately affected by the Interim Payment System," and recommends that HCFA continue to refine PPS to "create incentives for appropriate care to higher-cost beneficiaries." The Commission's IPS workgroup expressed that concern as it analyzed the strategies used during the first full year of operation under IPS, finding that agencies were "reducing or eliminating specialty services, and [were considering] closing branch offices."[89]

Medicaid Reimbursement for Home Health Agency Services

In addition to paying for home health agency care for its eligible recipients, Medicaid also administers a Model Waiver Program for the Medically Fragile. Under the Model Waiver, medically fragile individuals up to the age of 22 receive home care in two categories, "chronically sick children, and "rare and usual diagnostic groups". An important source for home care providers under this model waiver, whose referrals are handled by the Coordinating Center for Home and Community Care as Medicaid's agent, are the nurse registries, the employment-agency model described above. Originally, the CCHCC contracted with individual, licensed health care providers, but Medicaid and its contractor

[87] Commission staff continued to monitor the impact of changes in Medicare reimbursement on access to home health services through its ongoing data collection efforts as part of the IPS Workgroup, and in March 1999 surveyed Maryland home health agencies, requesting Medicare-specific information for the home health agency's first full year of operation under the IPS. The IPS Workgroup reconvened in January 2000 to review the analysis of data submitted by the 18 home health agencies with a full year of experience under IPS since their fiscal year reporting periods ended during September through December 1998.

[88] This study was a follow-up to a previous GWU study released in September 1999, *An Examination of Medicare Home Health Services: A Descriptive Study of the Effects of the Balanced Budget Act Interim Payment System on Access to and Quality of Care.*

[89] *Maryland Home Health Agency Statistical Profile and Trend Analysis, Fiscal Year 1998*, pp. 31-32.

made an administrative decision to work through employment agencies, in addition to using full-service home health agencies, when they have staff trained in high-tech, very specialized pediatric home health care. As of May 2000, there are 37 agencies registered with this program; 28 of these providers are home health agencies.

Government Oversight of Home Health Services in Maryland

•Federal Level

Health Care Financing Administration (HCFA)

• Medicare Conditions of Participation

As the federal agency with authority over Medicare's administrative, clinical, and reimbursement policies, HCFA effectively shapes the home health agency environment, and determines its direction as a covered benefit. HCFA established, and periodically updates, the Medicare Conditions of Participation, standards by which HCFA's contracting agency in each state – in Maryland, the DHMH Office of Health Care Quality – evaluates home health agencies and certifies them for participation in, and reimbursement by, Medicare. The Conditions of Participation are also used by many state Medicaid programs, Maryland's among them, to determine eligibility for participation in and payment by that federal-state entitlement program.

The Medicare Conditions of Participation currently in effect (42 CFR Ch. IV, 10-1-99 Edition) list fifteen areas in which a prospective new or an existing home health agency must comply with HCFA standards. Conditions related to Administration establish standards related to:

- **patient rights,** including the right to written notice, the right to be informed and to participate in planning care and treatment, the right to confidentiality of medical records, rights regarding payment for services, and the right "to be advised of the availability of a toll-free HHA hotline in the State";

- **release of patient identifiable OASIS information**, which must be kept confidential and may not be released;

- **compliance with Federal, State, and local laws, disclosure and ownership information, and accepted professional standards and principles**, which includes a list of information on agency ownership that must be disclosed to the State survey agency;

- **organization, services, and administration**, which includes a total of ten standards that outline details of the required organizational structure and array of clinical services, requires all administrative details to be "clearly set forth in writing," and prohibits administrative and supervisory functions from being delegated to another agency or organization;

- **the "group of professional personnel"** stipulates that a group of health professionals including at least one physician and one registered nurse, with

"appropriate representation from other professional disciplines," must establish and annually review the agency's policies concerning scope of services, admission and discharge policies, medical supervision, clinical records, and other core activities of the agency;

- **acceptance of patients, plan of care, and medical supervision**, which requires a regularly updated, written plan of care, developed "on the basis of a reasonable expectation that the patient's medical, nursing and social needs can be met adequately by the agency in the patient's place of residence," and regular updates of that plan, in conformance with physician orders; and

- **reporting OASIS information**, which requires electronic reporting of OASIS data, whose collection is itself a Condition of Participation.

Other Medicare Conditions of Participation sets standards for the "furnishing of services," including **skilled nursing services** by registered and licensed practical nurses; **therapy services,** including occupational, physical, or speech therapy; **medical social services** by or under the supervision of a qualified social worker**; home health aide services**, describing the qualifications required for these workers and also Medicaid personal care attendants; **outpatient physical therapy or speech pathology services**, which must meet specialty Conditions of Participation; **clinical records**; **annual agency evaluations**; and a **comprehensive assessment of patients**, which requires submission of a specified body of OASIS data.

•***Reporting of OASIS Data***

As part of the Balanced Budget Act of 1997, and its measures designed to increase the accountability of the nation's home health agencies for both financial performance and clinical outcomes, HCFA established the Outcome and Assessment Information Set ("OASIS") as a data reporting vehicle, and began developing the format and data items the system would collect. As noted in the Conditions of Participation, the Secretary of Health and Human Services designates the OASIS data items that must be included in the required comprehensive patient assessment.

These items must include "clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care," and "any data items that have been collected at inpatient facility admission or discharge."[90]

The HCFA website notes that two rules have been finalized relating to the use of OASIS by home health agencies: one revises the existing Conditions of Participation to

[90] Interestingly, HCFA's website notes that these data items "should be a part of a comprehensive patient assessment, but we emphasize that the OASIS was not developed as a comprehensive assessment tool." *See* www.hcfa.gov/medicaid/oasis/hhoview.htm.

require that Medicare-certified home health agencies begin collecting OASIS data, and the other adds to that revision the requirement that these data be reported to the State survey agency. In Maryland, the OASIS data will be first submitted to the DHMH Office of Health Care Quality. HCFA's website advisory notes that "the State [survey agencies] will have the overall responsibility for collecting OASIS data in accordance with HCFA specifications," and will also be responsible for preparing the data for "retrieval by a central repository to be established by HCFA." The electronic submission of OASIS data is tied directly to the PPS reimbursement system, "which depends on the data acquired by the OASIS system."

This HCFA Internet update makes quite clear that -- soon after October 1, 2000 and the advent of PPS for home health agency care -- there will be a direct linkage between the ability of home health agencies to submit complete, accurate, and timely OASIS data, and the OHCQ's ability to collect the data and convey it to the HCFA "central repository," and the ultimate level of Medicare payment a home health agency can and will receive.

•State Level

Department of Health and Mental Hygiene. Since 1978, home health agencies in Maryland have been required to obtain a license to operate from the Department of Health and Mental Hygiene, Office of Health Care Quality ("OHCQ"). The Office of Health Care Quality acts as Medicare's agent, surveying home health agencies with respect to their compliance with the Medicare Conditions of Participation as well as general licensure provisions (see COMAR 10.07.10). These Federal requirements, as noted above, address personnel qualifications, including detailed rules for the duties and training of several kinds of personnel; patient rights, organization, services, and administration, including staff supervision, personnel policies, and institutional planning; acceptance of patients and plan of care; clinical record-keeping; and program evaluation.

Investigations of quality of care complaints about a specific Home Health Agency may require an on-site visit by OHCQ and review of the patient's medical records and other pertinent documents. Under Federal regulations, Home Health Agencies may be surveyed every one to three years depending on their ability to meet certain criteria. The majority of home health agencies in Maryland fail to meet the criteria that would permit a survey every three years and must be surveyed annually.

There are no survey requirements for Residential Service Agencies, Nursing Staff Agencies and Employment Agencies that refer workers to provide home-based health care. Yet these organizations can provide services often equal to a Home Health Agency. Current licensure requirements for Residential Service Agencies focus on a paper review and do not impact on the quality of health care services provided. A similar complaint regarding services provided in a Residential Service Agency, Nursing Staff Agency, or Employment

agency cannot obtain the same level of investigation because these entities are not required to maintain the same level of documentation. Consequently, there is not a clear mechanism for monitoring quality of care or conducting investigations in Residential Service Agencies, Nursing Staff Agencies and Employment Agencies that refer workers to provide home-based care.

Health Professional Boards. The purpose of the DHMH Health Professional Boards and Commissions is to ensure that the highest quality health care is provided to the citizens of Maryland. The various Boards issue licenses to practice in the State of Maryland. It also investigates complaints and takes disciplinary action against licensees when necessary. Each board follows the ethical guidelines and standards of the profession it regulates.

Professionals such as nurses, social workers, occupational and physical therapists, speech pathologists and pharmacists all may provide home health agency services in patients' homes, under the scope of practice permitted by their occupational licenses. In addition, the Board of Nursing is specifically charged with overseeing Nurse Staffing Agencies, one of the categories of provider that may care for patients in their homes without a CON or the requirement to meet Medicare's Conditions of Participation. Any complaint or other action taken with regard to home care provided by one of these licensed or certified health professionals can be taken to the respective Board.

Maryland Department of Aging. The Long Term Care Ombudsman Program under the Older Americans Act (OAA) is charged solely with advocating on behalf of residents of long-term care facilities, which are described in the act as nursing homes, board and care homes, and similar adult care facilities. The definition does not include hospice and home health care. Some state ombudsman programs have received additional state funding to respond to needs in these settings, but they are not within the program's purview, as outlined in the federal OAA.

Maryland Health Care Commission. Through its statutory authority and responsibilities under Part II ("Health Planning and Development"), Subtitle 1 ("Health Care Planning and Systems Regulation"), of Health-General, Article 19 of Maryland's Annotated Code, the Maryland Health Care Commission (MHCC) is responsible for the development and administration of the State Health Plan.[91] In turn, the State Health Plan provides the policies, review standards, and need projections against which applications for Certificate of Need are evaluated. Consequently, the SHP is fundamentally a policy and procedural guidebook for Commission decisions on the establishment and activities of health care providers and services defined by law [92] as "health care

[91] The Comprehensive Standard Health Benefit Plan for Small Businesses established by the Commission includes a home health benefit "as an alternative to otherwise covered services in a hospital or other related institution."

[92] The statute defines "health care facilities" for purposes of CON review at §19-114(e), and delineates the actions by proposed or existing health

facilities" requiring CON review and approval.

Through the CON program, the Commission regulates market entry and, in many cases, exit from the market by these health care facilities, determines whether they may establish or close individual medical services[93], and reviews proposals to expand or reduce service capacity.

Market Entry

Since the enactment of the statute creating the former Maryland Health Resources Planning Commission in 1982, home health agencies been included in the definition of "health care facility" for purposes of coverage by CON review requirements.[94] However, since most home health agencies existing at that time[95] had been created by hospitals or nursing homes as a facility-based medical service, statutory language was added at several junctures over the next several years[96] to clarify further how the HRPC's Certificate of Need requirements applied to prospective new or expanded home health agencies. Existing programs of both kinds rushed to be "grand-fathered" as these successive additions to Commission and licensing law established additional requirements.[97]

Before 1984, nothing in law explicitly prevented existing home health agencies from creating new branch offices and selling them, thereby creating new home health agencies without CON review and approval. The first State Health Plan, issued in 1983,

care facilities that require CON review and approval at §19-123.

[93] A list of the "medical services" regulated by the Commission was added to statute in 1988: "(1) Medicine, surgery, gynecology, addictions; (2) Obstetrics; (3) Pediatrics; (4) Psychiatry; (5) Rehabilitation; (6) Chronic care; (7) Comprehensive care; (8) Extended care; (9) Intermediate care; or (10) Residential treatment; or . . . [a]ny subcategory of the rehabilitation, psychiatry, comprehensive care, or intermediate care categories of health care services for which need is projected in the State health plan." §19-123(a)(4).

[94] Chapter 21, Acts of 1982 added the requirement for home health agencies to obtain State licensure. This statute was amended by Chapter 566, Acts 1986 to include a required annual report to the then-Office of Licensing and Certification Programs in DHMH, as well as the statement that obtaining a license "does not waive the requirement for a home health agency to obtain a certificate of need." §19-404(d).

[95] Because Medicare's Conditions of Participation included a requirement that proprietary home health agencies be licensed – and few states required the licensure of home health agencies in addition to Medicare certification – most proprietary agencies were excluded from Medicare participation. Although this restriction was removed in 1980, home health agencies existing at the initial imposition of CON approval in 1982 and the clarification of the requirement in 1984 were largely not-for-profit, and most were services created and operated by health care facilities.

[96] Chapter 681 Acts 1984, and Chapters 688 and 767, Acts 1988.

[97] The 1984 amendment made explicit that an existing home health service operated by a facility or an existing freestanding home health agency was required to obtain CON approval before establishing a new agency or branch office, expanding its geographic service area, or separating and then selling a branch office to create a new home health agency. The 1988 amendment provided that as long as a home health agency established by a facility without a CON between January 1 and July 1(the effective date of the new law) of 1984 did not exceed $333,000 in annual operating revenue, no CON would be required. Those established (or expanded) prior to January 1, 1984 were also excluded from the impact of this change.

noted the inequity of this practice, since anyone else proposing a new home health agency was required to obtain a CON. Hospitals and nursing homes were permitted to set up home health services under their existing licenses, provided that they did not exceed new-service revenue thresholds then in effect.[98] In 1984, the legislature added provisions that explicitly required CON approval to establish a new home health agency, branch office, or home health care service within a health care facility; to expand an existing home health agency beyond its present approved jurisdictions[99]; and to transfer the ownership of either a branch office or a facility-based home health service. Twenty-nine home health agencies were grand-fathered prior to the effective date of the 1984 amendments.

The statute regarding expansions by facility-based services required still more explicit clarification: in 1988, language was added to Commission home health statute explicitly stating that CON was required for "the expansion of a home health service or program by a health care facility" that was established "without a certificate of need between January 1, 1984 and July 1, 1984," (i.e., during the consideration of the 1984 amendments restricting unlimited expansion by facility-based home health services, but before their effective date), and that would have annual revenue greater than $333,000, appropriately adjusted for inflation. The result of both of these statutory amendments was that, at the time of the HRPC's report to the legislature on community-based services in 1993, "less than one-third of existing home health agencies were reviewed and approved for Certificates of Need."

Another factor in the history of the Commission's regulation of entry into the market by home health agencies has been its interpretation of key provisions of its statute, regulations, and administrative precedent, and the impact that those interpretations have had on the CON requirement for new or expanded home health programs.

The first of these determinations followed as a result of the grand-fathering of existing and operating programs that took place after the effective dates of both the 1984 and the 1988 statutory amendments. Since home health programs that existed before either the CON or the licensure requirement had no geographic limitation on their service areas, the grand-fathered programs were determined to have a statewide service area. This was reinforced by the argument that -- since so many of these pre-existing home health had been established as medical services within hospitals or nursing homes, which may serve a resident of any Maryland jurisdiction (and in the case of facilities with specialized services, often draw patients from across the state) – their home health

[98] *Study of Community-Based Long Term Care Services*, p. 32. This study by the former HRPC was mandated by 1993's HB 1066, in response to the fragmentation and unequal levels of regulation among various categories of in-home direct care providers. This section of the report also notes that many of the hospital-based home health agencies were reorganized as freestanding agencies as a result of encouragement by HSCRC, which did not want to set outpatient hospital rates for these services.

[99] From the first State Health Plan, issued to cover the period 1983 through 1988, the need projection methodology for home health agencies has been calculated on a jurisdiction-specific (i.e., county) level.

agencies had similar geographic scope, so as to be able to "follow their patients."

Another exception to the CON requirement for new home health agencies, and for expanding the service area of an existing program to additional counties, extends to home health programs operated by health maintenance organizations, *if they are serving their own subscribers*. Both Commission statute and CON procedural regulations state the permission to serve subscribers -- either without CON approval, or without CON approval in a jurisdiction not already CON-approved – in the negative: a CON is required for any "health care project" for which a CON is otherwise required, "if that health care project is planned for or used by any non-subscribers of that health maintenance organization."[100] COMAR 10.24.01.02D(3) requires CON approval for any health care project by an HMO "if that health care project is planned for or could be used by non-subscribers. .. ." This provision complicates home health data collection, since an HMO-based agency may care for its subscribers in jurisdictions where it is not authorized to care for any other member of the public.

Consideration of CON for Proposed New Home Health Agencies

Although few of the older agencies originally obtained CON approval, since the late 1980s entry to this market as a full-service, Medicare-certified home health agency requires a Certificate of Need: to establish a home health agency, to establish a new branch office for a home health agency, or to expand an existing agency's service area into a new jurisdiction.[101]

A prospective new agency may apply as a general home health agency seeking to serve one or more jurisdictions in a health service area, or it may apply as a "specialty" home health agency, defined in the Plan as an agency that provides:

- Services exclusively to the pediatric population;
- An array of services exclusively to a population group limited by the nature of its diagnosis or medical condition, such as high-risk maternity patients or AIDS patients;
- To all population groups a highly limited set of services that can offer acceptable quality only through specialized training of staff and an adequate volume of experience to maintain special skills; or
- Services exclusively to members of a continuing care retirement community.[102]

Specialty home health agencies are not subject to a demonstration of need according to the methodology in the Plan, but instead must show, through an analysis of their intended target population and their volume and financial projections that the services they propose are needed.

[100] Health-General Article §19-124(b)(ii).

[101] Branch offices are major administrative centers, where clinical records are kept and new clients may be admitted. Satellite offices are locations where home health care supplies are stored, and are established as a kind of "field office" for direct care personnel.

[102] COMAR 10.24.08.08B(25)(b)

Applications to establish or expand a general home health agency are subject to the Plan's need projections and special rules govern the docketing and approvability of these CON applications. If no need for additional home health clients is projected for a particular jurisdiction in the current target year, the Commission will not accept or docket applications. Another rule precludes the Commission's approval of a new home health agency in a jurisdiction unless the number of additional home health clients to be served is above 350 additional clients.[103] At the present time, no net need for home health agency clients remains from the 1997 update of the year 2001 projection[104] sufficient to permit a new or expanded program in any jurisdiction; Staff periodically updates the inventory and need projection, to determine if scheduling a CON review is warranted in any jurisdiction.

The calculation of net need for new home health treatment capacity by a specified target year begins by identifying, for each jurisdiction, the percentage by which its age-adjusted population is projected to change in a six-year period between the base and target years, and multiplying the number of hospital discharges to home health care by that ratio of projected population growth. The projected gross need for home health capacity is the sum of these projected hospital discharges plus a projected number referred from other sources. Adjustments for residents of each jurisdiction who received home health care from agencies based in another county or another state produce a number of home health clients in the base year, and the net new need for home health capacity is expressed as a minimum-maximum range of difference between the current utilization figure and the projected gross need in the target year. The capacity of the existing system is based on current utilization. This method is described completely in the State Health Plan's section on need methodologies (COMAR 10.24.08.07B), which identifies the underlying assumptions regarding utilization, data sources, time periods, geographic areas, and source of existing inventory.

In its application for CON approval by the Commission, a proposed new general home health agency must demonstrate consistency with the standards for CON review in the Long Term Care Services section of the Plan (COMAR 10.24.08.06), and address the general review criteria in the CON procedural regulations. The State Health Plan requires an applicant for CON approval as a general home health agency to describe the configuration of any agency proposed to serve multiple jurisdictions, including the location of its main office and any branch or satellite offices. Regarding its financial accessibility, each applicant must be "or propose to be" certified by both Medicare and Medicaid, and commit to accept clients with those programs as their primary payment source; each applicant must also

[103] An adopted SHP need projection for a target year is a ceiling, and does not compel the Commission to approve an otherwise unapproveable application, or, after considering the impact a new agency would have on existing programs, to approve any new capacity.

[104] The 2001 home health agency need projection in *COMAR 10.24.08 State Health Plan: Long Term Care Services*, Appendix D.

document a time payment plan and a sliding fee scale, and commit to offering charity care equivalent to at least three percent of its gross revenue. A prospective new agency must submit a detailed plan for informing other health care providers and the public about its services, and document that its proposed fee scale is "not excessive" in relation to other agencies in its jurisdiction. Each applicant must submit a quality assurance plan consistent with applicable State and federal regulations, documentation of linkages with other health care facilities and providers and a discharge planning process, and also a written commitment not to discriminate against persons with HIV or AIDS.

Applicants to establish a specialty home health agency must meet these standards (in some cases, where appropriate, some would-be specialty providers may have certain standards waived), and also must address review standards for specialty home health agencies at COMAR 10.24.08.06 E. These standards require the applicant to "demonstrate quantitatively that there exists an unmet need that it intends to address," and to "demonstrate that its program will provide a more effective service for patients" than those available from existing agencies in the service area. In addition, since specialty agencies often provide care to extremely ill or medically-fragile children and adults with illnesses requiring complex or technologically sophisticated care, the applicant is required to demonstrate "how its program will reduce health care costs in other parts of the health care system," such as through the avoidance of institutional placement and care. A continuing care retirement community seeking to establish a "specialty" agency must commit to serve only its own subscriber-residents, and provide its residents with a list of other home health agencies operating in that jurisdiction.

Despite the current lack of projected need for new home health agencies, an avenue still open to either existing providers or would-be new providers is the acquisition of an existing program. Acquisition of an existing and operating health care facility – including home health agencies -- requires only that "the person acquiring the facility or service" to notify the Commission in writing "at least thirty days before closing on any contractual arrangements." This notice must stipulate that no change in capacity or services currently provided will occur as a result of the acquisition, and must also provide information on the previous calendar year's "admissions or visits," and the gross operating revenue from the previous fiscal year. Staff issues a determination of non-coverage by CON review, on its receipt of a complete notice of acquisition.

Market Exit

Market exit for a home health agency, under the Commission's interpretation of current law, is far simpler and less process-intensive than establishing or expanding a program. Although CON procedural regulations require Certificate of Need approval to close an existing medical service, or to close an existing health care facility,[105] Staff has

[105] COMAR 10.24.01.02A(4)(i) and (j); in the replacement Regulation .02 effective August 21,

interpreted the CON statute as permitting home health agencies to close without CON approval from the Commission. To require Certificate of Need review and approval for the closure of a health care facility or service seems counterintuitive, but the focus of such a review is on the impact of the proposed closure on continued access to the service by the affected population, on the remaining providers of the same service, and on the health care system as a whole.[106]

Since a CON is required for a change in the type or scope of health care services that results in "the elimination of an existing medical service"[107] but home health is not included in the list of what constitutes a "medical service," a CON has not been required for a home health agency to close. This has effectively saved small, financially-compromised providers significant transactional costs, and saved a corresponding amount of Commission and Staff time and resources, since – as noted above – forty-five home health agencies operating in the State have closed between January 1997 and May 2000.

Maryland Certificate of Need Regulation of Home Health Agency Services Compared to Other States

The Maryland Health Care Commission contracted a survey and study, to be conducted by the American Health Planning Association in June and July 2000. The purpose of this study was to: 1) identify current CON regulatory patterns for hospice and home health services nationwide, 2) document the duration and scope of these regulations and 3) identify and assess the effects of regulatory change over the last decade and a half on service capacity, use and expenditure levels in selected states. The study was based upon a national survey that included all fifty states and the District of Columbia.[108]

Initially, home health care was not among the services required to be regulated through CON by federal mandates. However, thirty-eight states and the District of Columbia included home health care as a regulated service in their programs. Since that time, twenty states have eliminated CON coverage of home health services, leaving 18 states plus the District of Columbia still regulating home health care through CON; twelve states never instituted CON regulation.

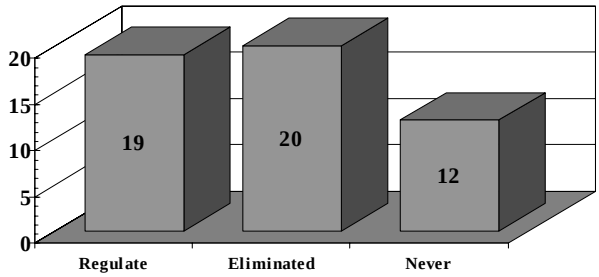
2000, this citation changes to subparagraphs (f) and (g) of the same subsection.

[106] See *In the Matter of the Closing of Church Nursing Center*, a closure CON approved by the Commission on April 20, 2000.

[107] Health-General Article §19-123 (j)(2)(iii)1.

[108] Maryland Health Care Commission, *Certificate of Need Regulation of Home Health and Hospice Services in the United States*, September 15, 2000.

Figure 4-1
Extent of CON Regulation by Number of States: U.S., 1991 - 1997



Of the twenty states eliminating CON regulation of home health care services, 11 of the 20 dropped regulation between 1985 and 1987, the period when federal support for CON programs was terminated. Two dropped planning controls in 1983 and 1984, one in 1989, five in the 1990s and 1 in 2000.

From 1967 to 1997, the number of Medicare-certified home health agencies grew from 1,753 to 10,807, a more than five-fold increase. The Balanced Budget Act, combined with Operation Restore Trust, had dramatic effects on home health use and on Medicare home health expenditures. Between 1997 and 1999, the number of certified agencies fell nationally from 10,808 to 7,747, a decrease of about 28%.

Home health was not a major component of the health care delivery system in 1968 when Maryland established its CON program. Maryland did not extend coverage to home health agencies until 1984. It was the last (most recent) state to do so. Consequently, among the states that now regulate the service, Maryland has regulated home health agencies for the shortest period of time. Of the nineteen states that currently regulate home health agencies through CON, three states (Kentucky, Mississippi, and New York) have imposed moratoria at some point. Pennsylvania, the other state with a moratorium on home health agency development, never regulated home health under its CON program.

Only 19 jursidictions now regulate home health under CON, but historical use patterns and trends suggest that such regulation may have restrained growth. Regulation of home health agencies appears to have helped restrain excess growth in the number of agencies established nationwide between 1990 and 1997, a period now shown to have been marked by both rapid legitimate growth in demand and by a number of excesses. The number of certified agencies increased by about 90 percent nationwide. In sharp contrast, the number of agencies in states with CON regulation increased by only about 38 percent compared with nearly 135 percent in

states that had eliminated CON regulation. The increase in Maryland was only 11 percent. AHPA surveyed the 50 states plus the District of Columbia. The states reported the utilization as presented in Table 4-12.

Table 4-12
Home Health Agency Use Rates By State and CON Regulation Status, United States, 1991-1997

State Category	Patients Per 1,000 Persons, 65 and Older		Visits per 1,000 Persons, 65 Years and Older		Percent Change 1991 – 1997	
	1991	1997	1991	1997	Patient Rate	Visit Rate
Continue Regulation (N=19)	48.9	110.6	2,340	8,285	126%	254%
Eliminated Regulation (N=20)	31.4	97.1	1,393	8,032	209%	477%
Never Regulated (N=12)	29.0	101.0	1,260	6,135	248%	387%
Maryland	**26.7**	**86.4**	**873**	**3,106**	**224%**	**256%**
United States	36.2	102.9	1,651	7,422	184%	350%
Source: AHPA, MD National CON Survey, June 2000						

Age-specific use rates for home health services vary widely among states. In 1991, the range was from an atypical low of 7 patients per 1,000 persons 65 and older in Hawaii to 92 per 1,000 in Rhode Island. CON does not appear to affect negatively home health agency population-based use rates. As seen in Table 4-12, the number of home health patients and home health visits per 1,000 (except that 1997 uses patients per 1000) appear to be higher in states with CON regulation compared to those who eliminated regulation and those who never regulated. Although the use rate, expressed as patients per 1,000 persons aged 65 and older increased substantially between 1991 and 1997, the states that continued to regulate experienced an increase of 126 percent, as compared to 248 percent for those who never regulated, and 209 percent for those who eliminated regulation. A similar pattern is seen for the visit rate. The increase in use rates in Maryland between 1991 and 1997 was comparable to those seen in a majority of states. The underlying patient and patient visit rates, however, remained near the lower end of the ranges seen among states nationally.

In summary, Maryland has included home health agencies in the services that it regulated through its CON program since 1982; since 1984 this statutory requirement has explicitly applied to any new home health agency or expansion by an existing agency into a new jurisdiction.

Home health activity is low in Maryland compared to other states. "It was one of a handful of states that saw little growth in the number of certified home health agencies during the 1990's. Growth rates in both were near the lower end of the range seen across states nationally. The age-adjusted home health care use rate, expressed as the number of home health patients per 1,000 65 years of age and older was about 84 percent of the national level in 1997. If the extraordinarily high rates in states with known excess are excluded, the Maryland rate is roughly comparable to that found nationally."[109] The average number of visits per home health patients is extraordinarily low in the State of Maryland. The 1997 Maryland rate was only about 42 percent of the national level, and was one of the lower rates nationally. The reasons for this are unclear. It may be partially explained by the relatively small number of proprietary home health agencies in the state. The level of Medicaid expenditures for home health may also be a factor. Patient volumes could also be affected by such factors as the number and type of Medicaid waiver programs in effect, and also by the availability of home health care personnel. Comparable state data are available nationally for Medicare- and Medicaid-certified home health agencies only. In addition to home health agencies, Maryland also has a substantial number of Residential Service Agencies (RSAs) that provide home care. The amount of care provided by RSAs is unknown, but the services provided by these agencies could be a factor in Maryland's relatively low Medicare home health use rate.

A conclusive explanation for Maryland's lower use rates, although it is possible to speculate about the possibilities outlined above, is not yet available. This important issue should be the subject of further study. It would be premature to conclude that Maryland's Medicare use rate represents a totally negative situation. Given the extraordinary excesses recently documented by Operation Restore Trust in a number of states with unusually high use, it may be nearer to what should be the norm than first appears.

[109] Maryland Health Care Commission, *Certificate of Need Regulation of Home Health and Hospice Services in the United States*, September 15, 2000

Alternative Regulatory Strategies: An Examination of Certificate of Need Policy Options

The options discussed in this section represent alternative regulatory strategies to achieve the policies, goals and objective embodied in Maryland's CON program. The role of government in these options describes a continuum varying from the current role (Option 1), to a more expanded role on one end of the continuum (Option 2), to an extremely limited role on the other end (Option 9). The options below, singly or in combination, represent potential alternative strategies considered by the Commission in conducting this study on CON regulation of home health care services.

Option 1 – Maintain Existing Certificate of Need Regulation

This option would maintain the CON review requirement for new or expanded home health agencies in current law and regulation. Under current law, establishing a new home health agency, or expanding an existing program into a county not already served by that agency, requires a CON. The Commission's decision on a given application is based on its review of a proposed project's consistency with the State Health Plan's CON review standards and need projections, and the general CON review criteria. As for exit from this market, Staff employs an interpretation, based on a close reading of statute that no Commission action is needed. In practice, only a written notification of the intended closure is required – although Staff often receives its initial notice of a closure from the Office of Health Care Quality that a licensure has been relinquished or not renewed. This interpretation has helped to avoid additional transactional costs for (generally) non-facility-based health care services seeking to cease operation.

As noted above, the current projections, for the year 2001, show no need for additional home health agencies in any jurisdiction in the State. However, given the regular updating and recalculation of need for home health agencies – particularly if any of the need methodology's assumptions were to be changed – a CON review schedule for home health agencies would be published in the *Maryland Register* whenever, and in whichever jurisdiction, net new need emerged.

Option 2 – Expand CON Regulation (Require CON or Exemption from CON to Close Existing Program)

Under the current interpretation of health planning statute, no CON has been required for the closure of an existing home health agency, since the list of "medical services" in §19-123 (a) does not include, and the list of "changes in type or scope of services" requiring CON approval does not explicitly include the term "health care facility" used in §19-114 for home health programs. This practice presumes that, if a particular home health agency closes, the other home health agencies in the affected jurisdiction or jurisdictions will absorb that patient load, if necessary by adding direct care staff.

One possible option for government oversight of home health agencies in

Maryland would be to intensify the level of CON oversight, by requiring Commission action, through CON or by a finding of CON exemption, on proposed closures. This increased level of scrutiny – which would examine the impact of an impending closure on continued access to home health services in the affected jurisdictions, and on remaining providers of care – would help the Commission determine whether one program's failure is an isolated event, or a warning of severe stress on the entire provider community. Based on its analysis of the proposed closure, Staff could recommend that the need projections be updated, and schedule a new CON review in the affected county.

Option 3 – Retain CON Regulation; Require CON for Residential Service Agencies

In 1993, the former HRPC considered, in its legislatively-mandated study of community-based health care, the idea of imposing the CON requirement on the relatively new category of residential service agencies, since these providers could circumvent CON by giving some subset of the skilled services that home health agencies had to provide. Noting that "the CON program cannot effectively regulate market entry and growth if only home health agencies . . . are covered" among the wide variety of entities providing in-home health care, the report pointed out that "home health agencies and residential service agencies can provide virtually identical services," but "only home health agencies must await governmental approval to enter the market . . . ."[110] The report observed that this regulatory inequity between the two types of providers "reduce the likelihood that the CON program can effectively operate as a substitute for the private market" in allocating the supply of "accessible, appropriate, and cost-efficient home care services."[111]

While the 1993 report stated clearly the problem with regulating market entry for some but not all providers in this industry, it also noted the disadvantages to requiring RSAs (or any other currently non-regulated provider) to obtain CON approval. Transactional costs would increase for both the RSAs and the Commission, and grandfathering of the 220+ existing RSAs would mean that the higher costs would be borne by a relative few would-be new providers.

Option 4 – Retain CON, but Regulate on Regional Rather Than Jurisdictional Basis

Although both home health agencies and hospice agencies have been regulated on a jurisdictional level since the first State Health Plan (1983-1988) defined its need projection methodologies on a jurisdiction level and the General Assembly clarified the Commission's authority over new and

[110] Health Resources Planning Commission, *Study of Community-Based Long Term Care Services. Part One: Home Care Services*, November 30, 1993, p. 33.

[111] The report focused in this analysis on the two entities providing home care that were licensed, then as now, as health care services, not on nurse staffing agencies, which check the health professional credentials of agency workers, or on nurse registries, which are licensed as employment agencies.

expanded programs consistent with that policy, nothing in statute precludes a regional, rather than a county-level need projection. Where the boundaries are drawn, short of the State's borders, is a matter of regulatory discretion, and may be defined in the State Health Plan.

The argument for a regional consideration of applications for community-based services provided largely in the home is one of administrative simplicity, underscored by the fact that geopolitical boundaries and those of health care service areas are frequently non-congruent. Requiring consideration of applications on a county-specific basis created a home health review for the Eastern Shore health service area in 1995-1996: for nine counties, a total of 21 individual CON applications had to be reviewed and analyzed, even though three of the applicants proposed to serve the entire Shore or large portions of it. This option would retain CON regulation, but conform the Commission's consideration of new or expanded agencies to the way health care services, particularly home- and community-based services, are organized and provided.

Option 5 – Require CON Only In Sole/Two Provider Jurisdictions

Another option is to impose CON review requirements only in jurisdictions with one or two home health providers, since the addition of another program into a small market has the real potential to destabilize and drive out of business one or both of the existing entities. In the large metropolitan counties, the scale of both geography and population would suggest that new competitors could be more easily absorbed.

The removal through closure of one or both agencies in a small market would create a similarly significant impact on access to these services, but could also be regulated under this option through a notice to the Commission. In response, the Commission could immediately schedule a CON review to consider a replacement, as the former HRPC did when Caroline County's health department closed its sole-provider hospice care program in 1997.[112]

Option 6 – Deregulate from CON, Create Data Reporting Model

Another option for home health care regulation involves replacing the CON program's requirements governing market entry and exit with a program of mandatory data collection and reporting. Deregulation through elimination of the CON requirement for home health care services is discussed in Option 8, and the implications of that option also apply here. Option 6 supports the role of government to provide information in order to promote quality health services. Performance cards, or "report cards" as they have come to be called, are intended to incorporate information about quality into decisions made by both employers and employees in their choice of health plans, and by consumers whose health plans permit a measure of choice in providers.

[112] As detailed in *An Analysis and Evaluation of the Certificate of Need Program in Maryland: Hospice Services*, the HRPC permitted agencies authorized in neighboring counties to serve hospice patients until the conclusion of the CON review.

Performance reports can also serve as benchmarks against which providers can measure themselves, and undertake improvements in any quality indicator in which they are found deficient. Report cards can both inform consumer choice and improve the performance of health care providers; how these effects manifest themselves depends on the intended audience. The data collection instrument already exists at the federal level, with the OASIS reporting requirement imposed by the 1997 Balanced Budget Act. This data is first reported to OHCQ, then transmitted to HCFA. The key element in getting the best data possible from the OASIS instrument is the clinical skills of the home health agency's respondent; OHCQ plans to intensify its current efforts to educate providers about OASIS data reporting.

♦6A – Public Report Card for Consumers for Home Health Agency Services

This option would add a home health agency report card to the Commission's growing list of public reports containing basic, service-specific information in a report card style format, promoting consumer education and choice. Home health agency report cards could be designed to report on these community-based services, according to a range of variables including administrative simplicity, availability and expertise of physician medical directors, and accessibility of nurses and other direct care professionals.

♦6B–Provider Feedback Performance Reports

Under this option, the Commission, or another public or contracted private agency, would establish a data collection and reporting system designed for use by providers – or, as noted above, the existing OASIS system could be adapted and used for this purpose. Like the report card option, this involves mandatory collection of detailed outcomes and process information from all home health services, in order to measure and monitor the quality of care using a selected set of quality measures specific to home health services. The purpose would be to provide feedback on how home health agencies and caregivers compare to their peers on issues such as staffing and utilization. This option assumes that if providers are fully informed about their performance in relation to their peers, and held more accountable for outcomes of care, they have sufficient incentive to achieve and maintain a level of high quality care. While CON (both historically and as it is now structured) is neither designed nor intended to monitor quality once an approved program begins operation, this option does further that objective.

Option 7 – Expand Department of Aging LTC Ombudsman Program

In Maryland, the Older Americans Act and Maryland law mandates the operation, under the authority of the Department of Aging and implemented by its county-level offices, of the Long Term Care Ombudsman Program. Ombudsman Program Coordinators act as advocates for residents of facility-based long term care services

such as nursing homes, assisted living facilities, and adult day care.

Under this option, the responsibilities and authority of the county Ombudsman would be expanded to include community-based services such as home health and hospice. Although progress has been made in establishing community-based service systems, many communities do not yet have the range of programs needed. Ombudsmen would develop a system to investigate complaints and identify system-wide deficiencies at a statewide level. Ombudsmen would protect the rights and personal autonomy of ill, vulnerable patients and their families, and monitor the level of care provided by the home health agency. This option envisions a cooperative and reciprocal relationship between the Office of Health Care Quality and the local ombudsman, depending on whether the focus of either a complaint or the identified solution involved advocacy for the individual patient, or was directed more at the agency itself.

This option would require additional funding and staffing resources for the Department of Aging's Ombudsman program.

Option 8 – Deregulate from CON; Expand Licensure Standards and Oversight

Under this option, the role of government oversight would shift from regulating market entry and exit to monitoring the ongoing performance of providers, through the expansion of existing licensure standards, and potentially also their application to any entity in the home care market. In addition to the quality of care issues traditionally the province of State licensure coupled with Medicare certification, this stronger licensing program could include and enforce some of the standards reviewed for initial compliance – or stated intent to comply – in current CON review. A commitment to provide an appropriate level of charity care and care for Medicaid recipients, linkages to other community health care providers, ready access to respite care, an active effort at communication and public information – all of these are CON review standards that could be incorporated into a more demanding and active program of State licensure.

This option offers the promise of rationalizing the entire uneven and somewhat confusing array of entities that currently, under varying levels of oversight by numerous State agencies, provide some level of health care in the home. It also offers the advantage of having been thoroughly examined. Senate Bill 782 enacted during the 1998 session established an Advisory Committee to the Secretary of Health and Mental Hygiene on the entire spectrum of "home-based health care services." Recognizing the rapid growth of the home care industry, and the related changes in the health care system as a whole, the General Assembly noted in SB 782 that "the current regulatory system . . . is fragmented, duplicative, and both over- and under-regulated." The Advisory Committee was charged to:

- Evaluate the current statutory framework for regulation and quality assurance of the home-based health care industry in Maryland, and to recommend whether oversight should be strengthened, streamlined, reduced, or eliminated; and
- Examine employment issues including payment and liability of benefits such as social security, workers' compensation, and unemployment insurance.[113]

As a result of the Advisory Committee's work, Senate Bill 359 was introduced for consideration in the 1999 session of the General Assembly. This proposal created a new, comprehensive licensure category of "community-based health agency," which placed all of the existing entities providing some level of health care in patients' homes under uniform administrative rules for employment practices, quality assurance, inspection, reporting, disclosure to clients, and complaint processes. The bill repealed all previous terms and entities, in effect defining "home health agencies" out of legal existence, and, functionally, out of the need to obtain CON approval prior to licensure. The basis for receiving Medicare reimbursement under this proposed regulatory framework would become whether an entity could meet the Medicare Conditions of Participation, not whether the entity had received CON approval from the Commission. Although the bill failed in 1999, at least partly because of the difficulties in resolving the issues raised by combining health care providers and employment agencies under the same administrative rules, the unevenness and fragmentation of oversight over home-based health care remains an issue.

Subject to limitations of staff resources, this option would require at least the same frequency of inspection as that of nursing homes, which are re-surveyed and re-licensed every three years. Under this regulatory model, through some series of graduated sanctions, prolonged failure to comply with the requirements of State licensure would ultimately result in the loss of the home health license as well as Medicare certification.

Option 9 – Deregulate from CON with or without Moratorium

In a time of severe shortages in direct patient care professionals, from registered nurses to aides to medical technicians, any expansion of a particular sector of the health care market – of capacity or of programs – may be problematic. Removal of restrictions on market entry, whether by CON or other means, raises the possibility that supply will increase.

Given that home health is overwhelmingly a Medicare-paid service, and that the referral rate from hospitals and other sources may be predicted, the impact of more providers may be lower case loads for all programs, coupled with staffing costs inflated by bidding wars for scarce nurses and technicians. The ensuing competition, between more players chasing limited staff and a constant number of patients for a pre-

[113] *Report of the Advisory Committee on Home-Based Health Care Services*, December 1, 1998, p. 1

determined level of reimbursement, may not drive down costs, but will winnow the field.

The response to this concern in some states that once regulated market entry for home health agencies through CON – or still do -- has been to impose a moratorium on new or expanded programs. Rhode Island has eliminated CON for home health agencies, but imposed a moratorium on new providers. Kentucky, Missouri, and New York retain their CON requirement but have also imposed a moratorium on new providers.

The effectiveness of Certificate of Need as a means of controlling costs and service capacity, and whether it represents the "best" regulatory tool for the job, has long been debated, particularly with regard to health care services not based in bricks and mortar. The last option, of course, is to deregulate home health agencies of all kinds from CON review, perhaps as a phased-in statutory change, and monitor the impact of this action. Even without enhancements to licensure standards and to data collection and reporting, considerable State oversight and information exists, and is accessible. This option would remove the CON review requirement from a low-to no-capital service, and would be consistent with the historic purpose of Certificate of Need review, which sought to prevent unneeded high-capital, facility-related health care projects.

Table 4-13 summarizes the policy options discussed in this section.

Table 4-13
Summary of Regulatory Options for Home Health Agencies

Options	Level of Government Oversight	Description	Administrative Tool
Option 1 Maintain Existing CON Regulation	No Change in Government Oversight	•Market Entry Regulated by CON •Market Exit Through Notice	Commission Decision: CON approval to create/expand
Option 2 Expand CON Regulation: Require CON for Closure	Increase Government Oversight	•Market Entry Regulated by CON •Market Exit Through CON	Commission Decision: CON or CON Exemption
Option 3 Expand CON Regulation: Require CON for RSAs	Increase Government Oversight	•Market Entry Regulated by CON •Market Exit by CON or Exemption	Commission Decision: CON or CON exemption
Option 4 Retain CON, but Regulate by Region, not Jurisdiction	Change Government Oversight	•Market Entry Regulated by CON for Defined Region •Market Exit Through Notice	Commission Decision: CON to create new regional agency, expand beyond region
Option 5 Require CON Only in Sole/Two-Provider Jurisdictions	Change Government Oversight	•Market Entry Regulated by CON to Enter Counties with 1 or 2 Programs •Market Exit Through Notice	Commission Decision: CON required only in 1 or 2 provider counties
Option 6 Deregulate from CON, Create Data Reporting Model	Change Government Oversight	•No Barrier to Market Entry or Exit	Performance Reports/ Report Cards
Option 7 Expand Department of Aging LTC Ombudsman Program	Change Government Oversight	•No Barrier to Market Entry or Exit; Close Monitoring of Care	Potential Sanctions by County Ombudsman for Substandard Care
Option 8 Deregulate from CON, Expand Licensure Standards and Oversight	Change Government Oversight	•No Barrier to Market Entry •Sanctions including Market Exit for Non-Compliance with Licensure Standards	Licensure Standards
Option 9 Deregulate from CON, with or without Moratorium	Eliminate All but Present Level of State Licensure, Medicare Certification	•No Barrier to Market Exit •No Additional Programs if Moratorium Imposed	None

Commission Recommendations

Recommendation 3.0
The Commission should continue its regulatory oversight of home health agencies through the Certificate of Need program.

Recommendation 3.1

The Commission will support efforts to reorganize the current statutory framework for licensure of home-based health care services to provide consistent and improved oversight for both home health agencies and residential service agencies.

Recommendation 3.2

The Commission will monitor the effectiveness of Certificate of Need oversight for home health agencies in light of the changing environment and periodically assess whether Certificate of Need regulation is still needed.

The Commission recommends that the General Assembly maintain existing Certificate of Need regulation for new or expanded home health agency services. Analysis of the public comments received in the process of conducting this study indicate no clear consensus on the future role of the Certificate of Need program in oversight of market entry for home health agencies. While implementation of the new Medicare prospective payment system for home health agencies appears on the one hand to have moderated incentives contributing to growth in the supply of agencies, on the other hand, it could be argued that the full impact of this new payment system remains to be evaluated. Another uncertainty considered by the Commission concerns both the final scope and timetable for reorganizing the licensure structure for home-based health agencies. A bill designed to create a community-based health agency licensure category was considered but did not pass during the 1999 session of the General Assembly. Given these factors, the Commission believes that it would be appropriate to continue oversight of market entry for home health agencies under the Certificate of Need program. While the future of government oversight for home health services should focus on on-going outcome assessment and quality improvement, the Commission recognizes that it is critical to have the appropriate infrastructure in place to enable this change in policy direction. The recommendation states the commitment of the Commission to support efforts to develop the necessary infrastructure. This recommendation also provides an opportunity for the Commission to evaluate the impact of changes in the Medicare prospective payment system on access, quality, and cost of home health care prior to considering a change in the regulation of market entry.